34-000 RURAL HEALTH CLINICS (RHC's)

34-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), a Rural Health Clinic must be certified by the Centers for Medicare and Medicaid Services (CMS) for participation in the Medicare program.

34-002 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

34-002.01 Health Maintenance Organization (HMO) Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan with the following exceptions:

1. Medical Transplants: As defined under 471 NAC 18-004.40, transplants continue to require prior authorization by NMAP and are reimbursed on a fee-for-service basis, outside the HMO's capitation payment;
2. Abortions: As currently define, abortions continue to require prior authorization by NMAP and are included in the capitation fee for the HMO; and
3. Family Planning Services: Family planning services do not require a referral from a primary care physician (PCP). As defined in 471 NAC 18-004.26, the client must be able to obtain family planning services upon request and from a provider of choice who is enrolled in NMAP. Family planning services are reimbursed according to the Nebraska Medicaid Practitioner Fee Schedule.

Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider shall provide services only under arrangement with the HMO.

34-002.02 Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. For services that require prior authorization under 471 NAC 18-004.01, the provider shall obtain prior authorization from the PCCM plan under the directions for prior authorization of the PCCM plan with the following exceptions:

1. Medical Transplants: As define under 471 NAC 18-004.40, transplants are subject to prior authorization by NMAP; and
2. Abortions: As currently defined, abortions require prior authorization by NMAP.

34-002.02A Referral Management: When medically necessary services that cannot be provided by the PCP are needed for the client, the PCP shall authorize the services to be provided by the approved provider as needed with the following exceptions:

1. Visual Care Services: All surgical procedures provided by an optometrist or ophthalmologist require approval from the PCCM plan. Providers shall contact the client's PCCM primary care physician before providing surgical services. Non-surgical procedure provided by an optometrist or ophthalmologist do not require referral/approval from the PCP; however, when an optometrist or ophthalmologist diagnoses, monitors, or treats a condition, except routine refractive conditions, the practitioner shall send a written summary of the client's condition and treatment/follow-up provided, planned, or required to the client's PCP.
2. Dental Services: Dentists or oral surgeons providing medically necessary services not covered under 471 NAC 6-000 shall bill that service on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837), using CPT procedure codes. These services require referral/ authorization from the client's PCP. The provider shall contact the PCP before providing these services. If a client requires hospitalization for these services, the provider shall contact the PCP for referral/authorization.
3. Family Planning Services: Family planning services do not require a referral from the PCP. As defined in 471 NAC 18-004.26, the client must be able to receive family planning services upon request and from a provider of choice who is enrolled in NMAP.

34-002.03 Mental Health and Substance Abuse Services Mental health and substance abuse services (MH/SA) are provided through the MH/SA managed care plan for all NHC clients. The plan includes the Client Assistance Program (CAP). Clients may access five services annually with any CAP-enrolled provider without prior authorization from the plan. All other MH/SA services must be prior authorized as directed by the plan.

34-003 Covered RHC Services: NMAP covers services provided by RHC's on or after July 1, 1990, under this chapter. NMAP defines covered rural health clinic services as the following services provided by a certified rural health clinic:

1. Services provided by a physician within the scope of practice under state law, if the physician performs the services in the clinic or the services are provided away from the clinic and the physician has an agreement with the clinic provided that s/he will be paid by the clinic for the services;
2. Services provided by a physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner if the services are provided in accordance with Medicare requirements;
3. Services and supplies that are provided as an incident to professional services provided by a physician, physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner;
4. Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biologicals) if -
    a. The clinic is located in an area in which the Secretary of the Department of Health and Human Services has determined that there is a shortage of home health agencies;
    b. The services are provided by a registered nurse or licensed practical nurse or a licensed vocational nurse who is employed by, or otherwise compensated for services by the clinic;
    c. The services are provided under a written plan of treatment that is established and reviewed at least every 60 days by a physician, physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner and review and approved at least every 60 days by a supervising physician of the clinic; and
    d. The services are provided to a "homebound" client. For the purposes of visiting nurse care, a "homebound" client is one who is permanently or temporarily confined to his/her place of residence because of a medical or health condition. The client may be considered homebound if the client leaves the place of residence infrequently. For this purpose, "place of residence" does not include a hospital or skilled nursing facility.

34-003.01 Other Ambulatory Services Provided by RHC's: NMAP covers other ambulatory services (other than those defined in 471 NAC 34-002) when provided by a certified rural health clinic and otherwise covered by NMAP.

34-004 Payment for Rural Health Clinic Services

34-004.01 Payment for Services Provided by Provider-Based Rural Health Clinics (RHCs): NMAP pays for RHC services provided by provider-based RHCs associated with hospitals of 50 beds or more at the reasonable cost rate per visit as established by Medicare. NMAP pays for RHC services provided by provider-based clinics that are associated with hospitals under 50 beds at the lower of cost or charges as established by Medicare. For those non-RHC services (see other ambulatory services in 471 NAC 34-003.01) for which no charge has been established by Medicare, NMAP makes payment according to the Nebraska Medicaid Practitioners Fee Schedule.

A provider-based RHC is defined as an integral part of a hospital, nursing facility, or home health agency that is participating in Medicare and is licensed, governed, and supervised by departments of the facility.

34-004.02 Payment for Services Provided by Independent Rural Health Clinics (IRHCs): NMAP pays for services to IRHCs at the reasonable cost rate per visit as established by Medicare. For those non-RHC services (see other ambulatory services in 471 NAC 34-003.01) for which no charge has been established by Medicare, NMAP makes payment according to the Nebraska Medicaid Practitioners Fee Schedule.

34-004.03 Cost Settlement for Provider-Based RHCs Associated with Hospitals of 50 Beds or More and IRHCs: The annual cost settlement will be calculated for each such clinic by multiplying its Medicare approved Encounter Rate by the number of encounters (all services per recipient per day equals one encounter). This figure is compared to the total amount paid for services during the cost settlement period.

34-004.04 Payment of Medicare Deductibles and Co-Insurance: For clients who are eligible for Medicare and Medicaid, NMAP shall pay the deductibles and co-insurance as determined by Medicare.

34-005 Billing for RHC Services: RHCs shall bill for rural health services as defined in 471 NAC 34-003 on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

IRHC's and provider-based RHCs associated with hospitals of 50 or more beds shall not bill radiology services. Payment for such services are included in the encounter rate.

IRHC's and provider-based RHCs associated with hospitals of 50 or more beds shall use Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) to bill NMAP for clinical laboratory services using the non-rural health clinic provider number.

Provider-based RHCs associated with hospitals under 50 beds shall use Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) to bill NMAP for clinical laboratory services and radiology services using the hospital provider number.

Providers shall use current HCPCS/CPT procedure codes when billing NMAP.

Effective 1/1/2001 payment for clinical laboratory services including collection of laboratory specimens by venipuncture or catheterization is made at the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare.